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Caregiver relations among African American children: a before and after picture of changes in caregiver

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by

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TABLE OF CONTENTS

ABSTRACT

In the event of family breakdown, removing the child from the home is one of the most common forms of state intervention, and is one of the primary interventions provided when a parent experiences severe problems related to caring for their children. This investigation examined predictors and consequences of the transition from one primary caregiver to another among African American youth. The sample consisted of African American children being raised by various members of their families including biological parents, relatives, and non-relatives. Respondents were participants in a large-scale study of African American children and their families, the Family and Community Health Study (FACHS). Children's level of depression and conduct disorder symptoms and school performance were assessed in order to compare the adjustment of children who reside with a biological parent compared to that of children who live with various other family members and non-relatives. Secondary data analysis revealed relatively few differences among children raised by various caregivers. Regardless of the caregiver relation to target, this study highlights the importance of a home environment that encourages a child's healthy behavioral and psychological development.

INTRODUCTION

Over two million children in the United States are being raised by family members other than their biological parents (Urban Institute, 2003). Research has suggested that disrupted family ties can be harmful to children removed from the care of their primary caregiver. Attachment theory predicts that nuclear family disruption may be less harmful if the child is maintained within the extended family (Geen, 2003; Iglehart, 1994). Kinship care arrangements are quite common in African American families and account for many of the living arrangements in which children currently reside.

The general aims of this investigation is (1) to identify factors that may predict a change in caregiver, (2) to better understand the kinds of changes that occur in the adolescent's life context after a change in caregiver, (3) to compare levels of depressive and conduct disorder symptoms and school performance among African American children being raised by family members other than their parents and children who are being raised by their biological parents, and (4) to identify characteristics of the new caregiving situation that may predict good versus poor outcomes of children in African American families. The consequences of the transition from one primary caregiver to another and the consequences of being raised overtime by the same caregiver among African American youth were also assessed in this study.

In the following sections, I will review literature on African American traditions surrounding kinship care, followed by a comparison of foster care to kinship care.

LITERATURE REVIEW

Placement Options

In the event of family breakdown, removing the child from the home is one of the most common forms of state intervention, and is one of the primary interventions provided when a parent experiences severe problems related to caring for their children (Lipscombe, Farmer, & Moyers, 2003). A child can be placed in foster care or kinship care. Either of these placements can be temporary if the parent can potentially resume the parental role later or permanent if it is unlikely that the parent will be able to assume the role again. Placements also can be either formal or informal. Formal arrangements involve court orders and some form of state involvement (Geen, 2003). Informal arrangements are those that do not involve the state or the court system (Geen, 2003). In the past, kinship care was typically arranged on an informal basis without the intervention of authorities. The problem with this kind of informal arrangement was that caregiving kin could not receive any financial assistance from the government to assist with providing care (Crumbley & Little, 1997). In most cases, the kin providing care are quite poor themselves (Crumbley & Little, 1997). Regardless of this challenge, there appears to be a sense of obligation in the African American community to provide care to youth who can longer be cared for by their parents (Geen, 2003).

Kinship Care

Kinship care occurs when a child cannot be cared for by his or her birth parents and instead lives with relatives such as grandparents, siblings, uncles and aunts, or close friends of the family, also known as "fictive kin" (Inglehart, 1994). In my study, I examined the relatedness to caregivers across all three waves of data collect. Research indicates that at times a parent is present in the home and simply cannot care for the child alone (Denby,

1996). This can be the case for teenage parents, parents with some form of disability or illness, drug-addicted parents, or parents with jobs outside of their immediate community. At other times, parents may be incarcerated or found to be unfit parents by the courts, in which case the child would be forced by the authorities to leave the home of their biological parents (Inglehart, 1994). To explore the predictors of a change in caregiver in the present study, caregiver variables, such as age, gender, and education level were assessed. This study also evaluated the mental health, legal problems and drug use patterns of the caregivers in the study as a way to better understand what caregiver variables might be important when examining changes in caregivers.

Even if the biological parents are in the home, they may not be able to adequately parent the child. Parenting covers a wide range of activities in addition to basic physical care and nurturance. Parenting includes proving guidance and discipline, while at the same time remaining warm and responsive. Parents are responsible for encouraging peer interactions, stimulating and promoting cognitive and intellectual growth, and also providing security and stability to a growing child (Lipscombe, Farmer, & Moyers, 2003).

African American Family Traditions

Since slavery, when parents and children were often separated, extended family members in African American families have been significant in children's development (Geen, 2003). Housing extended family members is one of the most important forms of aid that African American families provide. Extended family households include the head of household, spouse or partner, minor children, and other family members who reside in the household (Taylor, Chatters, & Celious, 2003). Nearly four out of ten African Americans

indicated that at some point their family had taken in a relative for at least a month's time (Taylor, Chatters, & Celious, 2003).

In African American families, relatives often step in to care for children because they want to preserve the child's connection to his or her family. When children are sent to be raised by someone who is not considered kin, there is a risk that they may lose sight of who they are and where they come from (Denby, 1996). In many African American families there is a very strong attachment to remaining loyal to one's family. Cole and Duva (1990) express the view that African Americans tend to believe that in order to preserve culture it is necessary to first preserve families.

Denbry and Alford (1996) identified shared parenting and pride in children as family preservation traditions in African American families, which may explain the preference for kinship over non-kinship care. Shared parenting is when raising a child becomes the responsibility of multiple members of a family. Raising children in African American families is typically seen as a collective effort that exists at both the family and community level. Collectivism, kinship networks, and egalitarian family units are major characteristics of the African American family (Denby, 1996). Strong kinship networks present emotional support that acts as a buffer to outside stressors and eventually helps preserve the family unit; they also provide concrete necessities such as child care, finances, and transportation (Denby, 1996). Another example of shared parenting is present in the disciplinary practices of many African American families. African American discipline is firm, caring, uncompromising, and is administered by any relative who feels compelled to do so (Deater-Deckard, Bates, Dodge, & Pettit, 1996).

The second component of family preservation, pride in children, can be best understood as a high value placed on children and their healthy development (Denby, 1996). When there is a birth in the family, it is seen as a blessing to the entire family and allows African Americans to continue their legacy by transferring "traditions, beliefs, symbols, language, ways of thinking, rules for interacting within African American cultures, and providing a foundation for what it means to be Black" (Dilworth-Anderson, 1992, p. 29). A child is a chance for the family name to be carried on and also a chance for family values to be passed on to another generation. When an African American person succeeds at a task, this is seen by most African Americans as a success of the entire race (Denby & Alford, 1996). For example, when one person in an African American family gets a high school or college degree, this is seen as the family's accomplishment.

Kinship Care versus Foster Care

Children who are moved to a new caregiver, whether with kin or not, face varying levels of disruptive and potentially traumatic experiences that may negatively affect their psychological development (Greeff, 1999). Being removed from their parents predisposes children to feelings of abandonment and rejection. If the pain of being separated goes untreated and is left unresolved, serious emotional and behavioral problems may develop (Starr, Dubowitz, Harrington, & Feigelman, 1999). Taking this into account, the present study examined the psychological and behavioral development of the children with changes in caregiver, along with their school performance.

Studies have found that a child's psychological and emotional stability may be more easily maintained when he or she remains in the family system than when the child is placed in non-familial foster care (Geen, 2003; Iglehart, 1994). A study by Geen (2003) found that

emotional problems are less severe for children who are placed with kin. Similarly, lower levels of internalizing and externalizing symptoms are associated with placements in kinship care in comparison to foster care (Berrick, Barth, & Needell, 1994; Dubowitz et al., 1994; Holtan, Ronning, Handegard, & Sourander, 2005). Iglehart found that adolescents in kinship care had more stable placements than adolescents in non-kinship care, such as foster-care. Ehrle and Geen (2002) hypothesize that the familiarity and continuity of kin placements may lessen the traumatic effects associated with separation from a biological parent. Given that, I compared children being raised by biological parents, relatives, and non-relatives.

Attachment

Attachment theory can help us understand why kinship placements are less disruptive than non-kinship foster placements. Attachment bonds between caregiver and child have been defined as persistent, non-transitory, emotionally significant relationships with a specific person (Ainsworth, Blehar, Waters, & Walls, 1978). The attachment bond with a caregiver is most commonly understood as a relationship where a child seeks security and comfort (Ainsworth, Blehar, Waters, & Walls). Attachment theory proposes that a key developmental task of individuals early in life is forming an attachment to a primary caregiver. According to Bowlby (1979), the relationship with a primary caregiver, usually the mother, is very important for the later functioning of a child. A study by Rice (1990) found that a healthy parent-child attachment is positively associated with social competence, identity, interpersonal functioning, self esteem, and emotional adjustment. Many studies have found that low quality of attachments and severed attachments are associated with higher rates of problem behavior (Cicchetti & Toth, 1998; Laible, Carlo, & Rafaelli, 2000; Marcus & Betzer, 1996; Raja, McGee, & Stanton, 1992).

If a positive attachment bond is not formed or if it is disrupted, children may grow to have a variety of interpersonal problems and negative psychosocial outcomes. Secure attachment bonds predict positive mental health outcomes for children, whereas insecure attachment bonds predict less positive mental health and behavioral outcomes (Marcia, 1980). The quality of attachment has been found to predict adjustment in many domains, including social, psychological, behavioral and cognitive domains (Cicchetti & Toth, 1998). Among adolescents, secure attachment is associated with lower levels of deviant behavior (Marcus & Betzer, 1996; Laible et al., 2000). The bulk of the literature on the quality of attachment and attachment disruption focuses on the relationship between infants and their parents (Stovall & Dozier, 1998; Tyler, Howard, Espinosa, & Doakes, 1997), but an understanding of the significance of attachment bonds in adolescents separated from their parents is equally important.

Howes (1999) found that children with prior relationship difficulties, when moved to a setting with a sensitive caregiver, are able to form new secure attachment bonds (Howes, 1999; Stovall & Dozier, 1998). In support of this finding, Howard and Medway (2004) state that children can form secure attachment bonds with others as long as the relationships are stable, consistent, and nurturing. By forming a secure attachment bond with a new caregiver, children may be able to avoid the negative consequences associated with poor parent-child relationships early in life.

Multiple Attachments

Attachments to multiple caregivers are possible. According to Bowlby's theory, there is a hierarchy of attachment relationships, with the mother as the primary attachment figure. Secondary, or alternative attachments are usually developed with fathers, older siblings,

grandparents, and significant teachers. This notion was supported by Howes (1999) who found that in addition to an attachment with the mother, a child can concurrently develop attachment bonds with fathers, grandparents, child care providers, and even teachers. A study by Jackson (1991), found that mothers and secondary caregivers of African American children were able to elicit comparable behavioral and emotional reactions from infants during the 'strange situation' test, thus indicating that multiple secure attachments can be formed.

In African American families there are often multiple family members who provide care and many attachment bonds exist between a child and various caregivers. Within the extended family, it appears that children construct multiple attachment relationship based on their unique experiences with various adult relatives. It has been proposed that since many African American children are raised in close proximity to many members of their extended family and have multiple attachment bonds, they have a smoother transition into kinship care arrangements than children from less cohesive kinship traditions (Brown, Cohon, & Wheeler, 2002; Crumbley & Little, 1997).

Challenges of Kinship Care

Although the transition into kinship care may be less traumatic than other placements, an adolescent in kinship care still faces many challenges, such as developing a positive view of self, adjusting to a change in caregiver, and resolving loss issues (Crumbley & Little, 1997). Children have to deal with the loss of the parents, which can be quite traumatic. Often, children think that it is better to have an absent or even abusive parent than not to have a parent around at all (Crumbley & Little, 1997). Children in kinship care may also have to experience the loss of siblings. Many children may withstand the loss of one or both parents

provided they remain with their siblings in placement (Crumbley & Little, 1997). If siblings are separated, children may experience strain in their relationships due to a number of reasons. One reason for a rift in the relationship among biological siblings placed in separated kinship care arrangements appears to be that children raised in different homes are taught different values and interaction styles (Crumbley & Little, 1997), which may prevent siblings from forming intimate connections.

Children in kinship care may also experience the loss of privacy and space. They may feel like an intruder in the kinship caregiver's home even if the caregiver is a relative or someone with whom they feel comfortable (Crumbley & Little, 1997). If the child had his or her own room at his parents' home but then has to share a room, there may be adjustment issues. Another major loss a child may experience is the loss of normalcy. He or she may feel that living with kin is something to be embarrassed about. He or she may secretly wish to live with his parents like other children (Geen, 2003).

The transition into kinship care, even high-quality care, is not the end of turmoil for the child. Studies have found that children raised in environments with depressed or drug and alcohol addicted parents still bear the burden of their earlier life with a caregiver who did not provide them with optimal care (Hammen, 1999; Obot & Anthony, 2004). This is true for children even if they are removed from the care of the troubled parent (Starr, Dubowitz, Harrington, &Feigelman, 1999). Hammen (1999) reported that children with depressed parents tend to have higher levels of both internalizing and externalizing symptoms than children with non-depressed parents. Obot and Anthony (2004) found the same pattern in children of alcohol dependent parents.

Once in kinship care, children may require help to understand the facts surrounding the separation and to work through their feelings about the separation (Martin, 2000). Being removed from their parents predisposes children to feelings of abandonment and rejection. Research has shown that older children react to separation with feelings of loneliness, fear, embarrassment, stigma, and behavior problems (Hale, 1988; Hungerfold, 1993; Thompson & Harm, 1995). Kinship caregivers can help children through this healing process by demonstrating understanding, tolerance and acceptance of the child and his or her situation (Martin, 2000). Interactions such as this between the kinship caregiver and the child may lead to the development of a positive and healing relationship.

In addition to patience and understanding, good parenting by the new caregiver is an important determinant of displaced youths' adjustment. Parental involvement can have a protective effect against psychological maladjustment in adolescents from non-intact families (Williams & Kelly, 2005; Hamilton, 2005). For this reason, parenting practices and parenting quality was included in the data analysis for the present study. A study by Hamilton (2005) examined the association between adolescent well-being and the involvement of non-parental adults all residing under one roof. It was found that the involvement of grandparents was related to less adolescent deviance and lower depressive symptoms among African American adolescents. However, Hamilton stated that other non-parental adults in the home may not have the same impact on adolescent deviance or adolescent depression. The impact on the child's life on the part of the grandparent may be related to a grandparent's level of investment in the child's life in comparison to a distant relative.

Outcomes

Just because a child has experienced adversities in relation to parents, he or she is not necessarily in danger of adjustment difficulties later in life (Howes, 1999). The outcomes of placements may depend on the characteristics of the kinship caregivers, their environment, and the child's personal qualities (Johnson-Garner & Meyers, 2003). Placements can either be helpful or challenging environments for the child. Successful placements are those where children trust that if they connect to another adult, then this adult will not abandon them as they may perceive that their biological parent has done. Resilient children in kinship care placements generally reside in homes characterized by structure, clear boundaries, and well defined roles. The family also tends to be very close emotionally, have open communication, and have the ability to adapt to change well (Johnson-Garner & Meyers). Taking this into consideration, I examined the caregiver situations after changes in caregiver that predict good versus poor outcomes in children.

Placements that are more challenging for children to adjust to are those environments where the caregiver is poor and resources are inadequate and where the kinship caregiver has psychological problems (Ehrle & Geen, 2002). In light of the previous finding, I examined neighborhood poverty and caregiver receipt of public assistance. Unfortunately, many kinship families fall into this category. Kinship families who provide care tend to be single parent households, where the caregivers are poorer, older, and have less formal education than non-kin foster parents (Ehrle & Geen, 2002). Children in kinship care arrangements may have experiences that include, but are not limited to economically distressed communities, lack of a positive peer relationships, and varying levels of caregiver distress (Taylor, Seaton,

& Rodriguez, 2002; Ehrle & Geen, 2002) . Stressors of these types can make positive psychological adjustment more difficult.

Present Study

Much of the literature to date compares kinship care arrangements to foster care arrangements. This investigation examined predictors and consequences of the transition from one primary caregiver to another among African American youth.

Using data collected in a longitudinal study, this investigation answered the following six questions:

1. What predicts a change in caregiver in African American children?
2. What changes in the adolescent's life context occur after a change in caregiver?
3. What kinds of mental health and behavioral changes can be seen in adolescents who have changed primary caregivers, compared to those who have not changed caregivers?
4. What characteristics of the new caregiving situation predict good versus poor outcomes of the child?
5. At each time point, was there a significant difference in the number of conduct disorder symptoms, depressive symptoms, and school performance for children who are currently in the home a biological parent, other relative, or a non-relative?
6. Was there a significant difference in the number of conduct disorder symptoms, depressive symptoms, and school performance for children who were consistently raised by biological parent, relatives, and non-relatives?

METHODS

Participants

In 1997, data were collected from 897 African American children and their families, 475 in Iowa and 422 in Georgia, all of whom included a child who was 10- to 12- years old at the first wave of data collection. The children were participants in a large-scale study of African American children and their families, the Family and Community Health Study (FACHS). Forty-six percent (417) of the children were boys and 54% (480) were girls. Participants were recruited from both Iowa and Georgia. Recruitment rates did not differ significantly across sites, ranging from 61% to 68% (Cutrona, Russell, Hessling, Brown, & Murry, 2000). Each respondent was reimbursed $100 for participating in the study.

Procedure

Recruitment procedures differed somewhat in Iowa and Georgia. In both states, U.S. Census data were used to identify Block Group Areas (BGAs) that had at least 10% African American residents. In Iowa, U.S. Census BGAs in Waterloo (population 65,000) and Des Moines (population 193,000) met the sampling criterion. Families in these cities with African American children between the ages of 10 and 12 were identified through the public schools, which provided rosters of all African American students in grades four through six. In Georgia, BGAs that met the criteria were identified in small towns and a suburban area adjacent to Atlanta. Community members who served as liaisons between the University of Georgia researchers and the neighborhood residents compiled rosters of children who met the sampling criteria (African American children, between the ages of 10 and 12). Families were randomly selected from these rosters and contacted to determine their interest in

participation. Those who declined were removed from the rosters, and other families were randomly selected until the required number of families from each BGA had been recruited.

Instruments

The research protocol included a two-part interview administered during two separate sessions. Questionnaires administered during the interviews assessed neighborhood quality, stressful life events, personal characteristics, coping, social support, participation in religious activities, and psychological functioning. Only a subset of these measures were used in the current study. The measures were administered via Computer-Assisted Personal Interviews (CAPI), in which questions appeared in sequence on a laptop computer screen and were read aloud to the participant. Both the interviewer and the participant could see the screen. Interviewers entered participants' responses into the computer immediately following each question (Cutrona et al., 2000).

Demographics

Demographic variables included participant state of residence (Iowa or Georgia), participant age, education, gender, primary caregiver marital status and number of children in the home. Although it would have been desirable to include income as a demographic variable, a large number of participants refused to answer some or all of the income questions.

Neighborhood-Level Variables

Census-based. An index of community economic disadvantage was computed for each BGA on the basis of 1990 census data. We used the following variables to compute this index: percentage below the poverty line, percent receiving public assistance income, percent single mothers, percent male unemployment, and mean per capita income. The mean for each

of the BGAs was computed for each of the five economic variables. We then averaged the standardized means to create an aggregate economic disadvantage score for each BGA (Cutrona, Russell, Hessling, Brown, & Murry, 2000).

Conduct Problems. This construct was measured using caregiver reports about the child and child self-reports on the conduct disorder section of the Diagnostic Interview Schedule for Children version 4 (DISC-IV; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000). It was expected that caregivers would be less guarded than their children in providing information regarding the child's behavior problems. The caregiver's reports were limited, however, in that they would not be aware of some of the antisocial behavior displayed by their children. Therefore, the caregiver reports and the child self-reports were combined to form a composite measure. A series of questions assessed the individual's engagement in various deviant acts such as shoplifting, physical assault, lying, setting fires, cruelty to animals, vandalism, burglary, and robbery. The seriousness of the acts was also reported. The final symptom score takes into account both the frequency and seriousness of the events reported by the respondents. Reliability for the combined measures was .93 (Simons, Simons, Conger, & Brody, 2004).

Academic Performance. The target child completed a self-evaluation of his or her academic performance on a 5-point rating scale consisting of "superior student", "an above average student", "an average student", "a below average student", and "a far below average student."

Life Events. Child stressful life events were assessed with 47 items that asked respondents to answer yes or no to questions such as "Have you moved to a different house?" "Did someone else move into your house?" and "Did parents divorce?"

Mental Health. Primary caregiver's depression was assessed with 13 items taken from the Mini-MASQ (Clark & Watson, 1997). Respondents expressed the degree to which they felt withdrawn, felt nothing was enjoyable, felt lively, felt happy, and felt energy and were asked to indicate their level of agreement with items such as "felt depressed", felt distressed", and "felt hopeless." Items used a 3-point response scale consisting of (1) "Not at all", (2) "Somewhat", or (3) "Extremely." Reliabilities for these items was .87.

Major depression among the children in the study was assessed through clinical interviews with the target children using the DISC-IV. The major depression section contained questions pertaining to the frequency with which the respondent felt sad or depressed, experienced self-blame, had trouble concentrating, thought of death or dying, felt worthless, and so on during the preceding year. The DISC-IV may be used to generate both diagnoses and symptom counts (Kim, Ge, Brody, Conger, Gibbons, & Simons, 2003).

Psychiatric Diagnosis. Primary caregiver mental health was assessed with a structured psychiatric diagnostic interview, the University of Michigan Composite International Diagnostic Instrument (UM-CIDI; Kessler, 1991). The UM-CIDI was designed for administration by lay interviewers in large-scale community studies and is a modification of the National Institute of Mental Health Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, Williams, & Spitzer, 1981). The UM-CIDI was developed for the National Institute of Mental Health National Comorbidity Study and subsequently modified to yield DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th ed,; American Psychiatric Association, 1994) diagnoses. A variety of studies point to the validity of diagnostic classifications rendered by the CIDI (Kessler et al., 1994, 1998; Wittchen, Kessler, Zhao, & Abelson, 1995; Wittchen, Zhao, Abelson, & Kessler, 1996). In the current

study, I examined diagnoses of major depression in caregivers. The UM-CIDI also yields a list of illegal/recreational drugs and their frequency of use. I used the drug use index in the analyses as well as diagnoses.

Quality of Parenting Relationship. The primary caregiver's view of his or her relationship quality with the target child was assessed with 4 items that asked about satisfaction with and enjoyment of parenting the target child. Response scales asked for 4-point ratings on each item (e.g., (1) "Strongly Agree" to (4) "Strongly Disagree"). Items were reverse coded and scored so that higher scores represent more positive parenting. The reliability for the items was .78.

From the child's perspective, relationship quality with PC was assessed with 2 items that asked respondents to indicate their satisfaction with their relationship with their primary caregiver. Reliability for these items was .78.

Parenting Practices. The primary caregiver's views of their parenting practices were answered with 49 items ranging from (1) "Never" to (4) "Always." Items were scored so that higher scores reflected good quality parenting. Items tapped parental monitoring, consistent discipline, harsh discipline, inductive reasoning, nurturing and involved parenting, and positive reinforcement. Reliability was .78.

The child's views of the PC's parenting practices were assessed with 55 items, each on a scale that ranged from (1) "Never" to (4) "Always." Items were scored so that higher scores reflected good quality parenting. Subscales tapped parental monitoring, consistent discipline, harsh discipline, inductive reasoning, nurturing and involved parenting, positive reinforcement, and the child's identification with their caregiver. Reliability was .80. Because there were so many different parenting subscales from the caregiver's and the

child's perspective, a factor analysis was computed to see if a smaller number of underlying factors could be identified. The data were analyzed by means of a principal components analysis with oblimin rotation. Three parenting factors with eigenvalues above 1.0 emerged: Factor 1 - Child Positive Parenting, Factor 2 – Caregiver Positive Parenting, and Factor 3 - Caregiver and Child Negative Parenting. A scree plot confirmed the appropriateness of three factors. The factors and the variables that load on them are shown in Tables 1 and 2.

Table 1

Structure Matrix

	Component 1	Component 2	Component 3
Target rating of PC Nurturing	.913	-.132	-.161
Target rating of PC Monitoring	.913	-.132	-.161
Target rating of PC Inductive Reasoning	.732	-.209	-.67
Target rating of PC Warmth	.718	-.205	-.171
PC Inductive Reasoning	-.170	.764	.108
PC Positive Problem Solving	-.108	.640	.280
PC Positive Reinforcement	-.160	.630	-.038
PC Monitoring	-.139	.593	.130
PC Consistent Discipline	-.146	.602	.204
Target and PC Harsh Discipline	-.086	.067	.848
Target and PC Hostility	-.305	.059	.822
PC Harsh Discipline	-.057	.265	.462

Table 2

Factor Loading From Principal-Components Analysis: Eigenvalues, Percentage of Variance, and Cumulative Percentages

Factor	Eigenvalues	% of Variance	Cumulative %
1	3.15	28.62	28.62
2	1.62	14.79	43.41
3	1.46	13.30	56.71

Overview of Data Analysis Procedures

1. What predicts a change in caregiver among African American children?

To answer this question a logistic regression analysis was conducted predicting change in caregiver from Time 1 to Time 2 and from Time 2 to Time 3. The dependent measure in this analysis was a dichotomous variable in which "1" equals a change in caregiver and a "0" represents no change in primary caregiver. The following variables were entered as predictors in the regression equation: primary caregiver depression, number of illegal drugs used by the primary caregiver, primary caregiver legal problems, primary caregiver education, primary caregiver age, and neighborhood poverty level. Youth depressive and conduct disorder symptoms were also entered into the equation.

2. What changes in the adolescent's life context occur after a change in caregiver?

To answer this question a repeated measure analysis of variance (ANOVA) was conducted to examine changes that occur in adolescents' life context after they experience change in caregiver from Time 1 to Time 2 or from Time 2 to Time 3. Time was a within subjects factor and whether or not the youth experienced a change in caregiver between Time

1 and Time 2 or from Time 2 to Time 3 was used as a between subject factor. I tested for group effects and for interactions between group membership and time. A significant interaction signified differences between groups in changes over time in the dependent variables. Dependent measures included quality of parenting, parental mental health, and parental drug use.

3. *What kinds of mental health and behavioral changes can be seen in adolescents who have changed primary caregivers, compared to those who have not changed caregivers?*

To answer this question a repeated measure analysis of variance (ANOVA) was conducted to examine mental health and behavioral changes that occur in adolescents' lives after a change in caregiver from Time 1 to Time 2 or from Time 2 to Time 3. Time was a within subject factor and whether or not the youth experienced a change in caregiver between Time 1 and Time 2 or from Time 2 to Time 3 was a between subjects factor. I tested for group effects and for interactions between group membership and time. A significant interaction signified differences between groups in changes over time in the dependent variable. Dependent measures were anxiety and depression, the number of child conduct disorder symptoms, and school performance.

4. *What characteristics of the new caregiving situation predict good versus poor outcomes of the child?*

To answer this question a series of regression analyses were conducted. A separate regression was conducted predicting each of the following youth outcome measures: depressive symptoms, conduct disorder symptoms, and school performance. In each equation, the previous score on the outcome measure (before PC change) was entered first

and followed by demographics of the primary caregiver, parenting practices, parental depression, and child stressful life events.

5. *At each time point, was there a significant difference in the number of conduct disorder symptoms, depressive symptoms, and school performance for targets raised by a biological parent, other relative, or a non-relative?*

To answer this question a series of ANOVAs was conducted in which the independent variable was the relationship of the target child to his or her primary caregiver (biological parent, other relative, or a non-relative) and the dependent measures were number of conduct disorder symptoms, depressive symptoms, and school performance.

6. Was there a significant difference in the number of conduct disorder symptoms, depressive symptoms, and school performance for children who were consistently raised by biological parent, relatives, and non-relatives?

To answer this question a series of ANOVAs was conducted in which the independent variable was the consistent relationship of the target child to his or her primary caregiver (biological parent, other relative, or a non-relative) and the dependent measures are number of conduct disorder symptoms, depressive symptoms, and school performance. Only children who remained with the same caregiver across all three time points were included in the analysis.

RESULTS

Change in Caregiver

The focus of this study was on the adjustment of children with various caregivers. Some children experienced changes in caregiver over the course of the 3 waves of data collection. The change variable was assessed across children who experienced a change in caregiver from Time 1 to Time 2 and from Time 2 to Time 3 of data collection. The children's relation to caregiver at each time point is presented in Table 3.

Table 3

Relation to Caregiver at Each Time Point

Relation	Time 1		Time 2		Time 3	
	n	%	*n*	%	*n*	%
Biological Parent	796	89	691	90	683	90
Relative	62	7	37	5	47	6
Non-Relative	36	4	39	5	33	4

Table 4 shows the specific changes in caregivers made by children at each time interval. The relation of the child to the previous and new caregiver is shown. From Time 1 to Time 2 when children went from age 10 to age 12, there were 15 children who experienced a change in caregiver. Seven children moved from the home of a non-relative to their biological parents' home. Five children moved from the home of their biological parent to the home of a non-relative. There were 2 children who moved from the home of a relative to the home of their biological parent. One child moved from one non-relative to another non-relative.

Table 4

Number of Children with a Change in Caregiver from Time 1 to Time 2 and Time 2 to Time 3

Relationship Change	Time 1 to Time 2 (n = 15)	Time 2 to Time 3 (n = 12)
Non-Relative to Non-Relative	1	0
Non-Relative to Relative	0	0
Non-Relative to Biological Parent	7	4
Relative to Non-Relative	0	1
Relative to Relative	0	0
Relative to Biological Parent	2	2
Biological Parent to Non-Relative	5	5
Biological Parent to Relative	0	0
Biological Parent to Biological Parent	0	0

From Time 2 to Time 3 when the children went from age 12 to age 15, there were 12 children who experienced a change. Five children moved from the home of a biological parent to the home of a non-relative. Four children moved from the home of a non-relative to the home of a biological parent. Two children moved from the home of a relative to the home of a biological parent. One child moved from the home of a relative to the home of a non-relative.

Descriptive Statistics

Descriptive statistics were computed before analyses to address the study questions (see Table 3). Caregiver age ranged from 23 to 80 years old in this sample, with a mean age of 37.17 (SD = 8.17). This sample of primary caregivers was primarily female, in that only

7% (61 out of 897) of the sample was male. About 19% of caregivers reported earning less than a high school diploma. Forty-one percent of the sample reported graduating from high school graduate or receiving an equivalent diploma, while 30% of caregivers reported having some college experience or at least an Associates Degree. Six percent of the caregivers in the sample reported having a Bachelor's Degree, while 3% reported earning an advanced degree. Caregivers were also asked to report whether or not they were married at each time point. Over the three waves of data collection, caregiver marital status remained fairly consistent with about 37% of the sample being married. More means and standard deviations for primary caregiver and child variables are presented in Table 5. Few significant differences emerged for youth who changed caregivers in comparison to those who did not change caregivers. Negative parenting at Time 3, as indicated by a composite of both child and caregiver ratings, was lower for children with a change in caregiver in comparison to those who stayed with the same caregiver (t = -1.76, p <.10). Caregivers receipt of public assistance at Time 3was also less for children with a change in caregiver in comparison to those with the same caregiver (t = -2.35, p < .05). One last statistically significant difference emerged in the caregiver rating of legal problems at Time 1. The caregivers of children with changes reported fewer legal problems than the caregivers of children with no change in caregiver (t = -4.30, p <.01).

Correlations among study variables are shown in Appendix 1. Close examination of the table revealed some interesting relationships. Being raised by a stable biological parent across all three waves of data collection was significantly correlated with several variables. There was a significant negative correlation between stable biological parent and caregiver age (r = -.61, p < .01). Children were more likely to live consistently over time with a

Table 5

Means and Standard Deviations on Study Variables for Youth Who Changed Versus Youth Who Did Not Change Caregivers

	Time 1			Time 2			Time 3		
	M	*SD*	*t*	*M*	*SD*	*t*	*M*	*SD*	*t*
Child Variables									
Depressive Symptoms									
No Change	6.00	4.70		6.61	4.59		5.62	4.8	
Change	6.21	4.94	-.83	6.00	4.07	.15	5.63	5.4	.27
Conduct Disorder Symptoms									
No Change	1.66	2.55		2.78	3.02		3.31	3.47	
Change	1.98	2.34	-.36	3.18	3.04	-.99	3.70	4.00	-1.38
Stressful Life Events									
No Change	8.95	5.36		9.46	5.44		9.73	5.44	
Change	9.65	5.97	.76	8.98	5.35	-.56	9.38	6.09	-.36
School Performance									
No Change	3.46	.93		3.48	.76		3.51	.71	
Change	3.62	.88	1.12	3.52	.83	.35	3.60	.71	.82
Positive Parenting									
No Change	-.02	.81		-.03	.83		.01	.82	
Change	.16	.76	1.60	.16	.85	1.4	-.02	.92	-.24
Primary Caregiver Variables									
General Depression									
No Change	6.41	1.86		6.14	1.70	6.21	1.74		
Change	6.51	1.86	.36	5.97	1.53	-.66	6.03	1.49	-.74
Positive Parenting									
No Change	-.02	.66		-.11	.69		-.01	.68	
Change	.02	.59	.40	.04	.70	.46	.13	.86	1.03
Negative Parenting (with Child)									
No Change	.03	.73		.02	.73		.04	.78	
Change	.04	.84	.05	-.11	.96	-.86	-.16	.70	-1.76†
Public Assistance									
No Change	.41	.49		.30	.46		.24	.43	
Change	.35	.48	-.81	.20	.40	-.16	.11	.32	-2.35*
Legal Problems									
No Change	.03	.16		.09	.10		.03	.16	
Change	.00	.00	-4.30**	.03	.16	.65	.03	.16	-.04

$^{\dagger}p < .10$. *$p < .05$. **$p < .01$.

younger than with older caregiver. This may reflect movement of youth out of the home of aging grandparents. There were also significant negative correlations between stable biological parent and child conduct disorder symptoms at Time 1 (r = -.11, p < .01) and child conduct disorder at Time 2 (r = -.11, p < .01). By Time 3, the relationship between having a stable residence with a biological parent as the caregiver and child conduct disorder was no longer significant (r = -.05, p = .17).

Another interesting set of significant negative correlations was identified between caregiver age and negative parenting at all three waves of data collection: wave 1 (r = -.08, p < .05), wave 2 (r = -.11, p < .01), and wave 3 (r = -.12, p < .01). Thus, older caregivers engaged in less negative parenting than younger caregivers. Lastly, a significant negative relationship emerged between the child report of positive parenting and the caregiver report of the same skills at all three time points. Although both child and caregiver were rating the same behaviors, their perceptions were contradictory. Perhaps youth viewed strict parenting as negative whereas caregivers may have viewed such behaviors positively.

Analyses to Address Study Questions

1. What predicts a change in caregiver among African American children?

To examine what characteristics of the caregiver and child predict a change in caregiver among African American children a logistic regression analysis was conducted. The dependent variable was coded "1" if the child did not live with the same caregiver at all three time points and "0" if he or she did live with the same caregiver at all three time points. All variables entered into the regression equation were measured at wave 1. As can be seen in Table 6, these variables included demographic characteristics at wave 1 (caregiver age, gender, marital status, education, whether or not they received public government

assistance), the caregiver's level of depressive symptoms, past legal problems, and their use of legal and illegal drugs. Also, youth depressive and conduct disorder symptoms were entered into the equation. Results indicated that two variables were statistically significant and one was marginally significant in predicting a change in caregiver: caregiver age (B = .095, $p < .001$), caregiver gender (B = -1.461, p = .002), and caregiver education level (B = .296, p = .067).

The predictors of change in caregivers from Time 2 to Time 3 were the same as those from Time 1 to Time 2 (see Table 7). Caregiver age, education, and gender all emerged as

Table 6

Summary of Logistic Regression Analysis Predicting a Change in Primary Caregiver from Time 1 to Time 2

	B	*SE*	Wald statistic
Caregiver age	.10	.02	30.44**
Caregiver education level	.30	.16	3.36†
Caregiver gender	-1.46	.47	9.84**
Neighborhood poverty	.00	.01	.06
PC use of legal drugs	-18.45	10903.21	.00
PC use of illegal drugs	.96	.72	1.79
Youth Conduct Disorder	.02	.06	.13
Youth Depression	-.03	.04	.42
PC marital status	.25	.36	.47
PC legal problems	-18.84	8742.38	.00

†$p < .10$. **$p < .01$.

significant predictors of change in caregiver at Time 2: caregiver age (B = .12, p < .001), caregiver gender (B = -1.386, p = .019), and caregiver education level (B = .2, p = .008). These results indicate that the older the caregiver, the more likely it was that the child experienced a change in caregiver. Likewise, a change in caregiver was marginally significantly associated with higher caregiver educational attainment. Finally, children with a male caregiver were more likely to experience a change in caregiver.

Table 7

Summary of Logistic Regression Analysis Predicting a Change in Primary Caregiver from Time 2 to Time 3

	B	*SE*	Wald statistic
Caregiver age	.12	.02	32.58**
Caregiver education level	.20	.08	7.09**
Caregiver gender	-1.39	.59	5.54*
Neighborhood poverty	-.01	.02	.51
PC use of legal drugs	-18.09	11029.27	.00
PC use of illegal drugs	.78	.82	.92
Youth Conduct Disorder	.05	.07	.46
Youth Depression	-.06	.05	1.57
PC marital status	.14	.44	.11
PC legal problems	1.9	1.37	1.91

*p < .05. **p < .01.

2. What changes in the adolescent's life context occur after a change in caregiver?

To examine what changes occurred in the life context of children who experienced a change in caregiver a repeated measures ANOVA was conducted. Variables assessing quality of parenting, parental depression, receipt of government assistance, and parental drug use were entered into the equation. Analyses were conducted separately for changes in caregiver from Time 1 to Time 2 and for change in caregiver from Time 2 to Time 3. From Time 1 to Time 2, the aggregate parenting variables were not found to differ as a function of whether or not the child changed caregivers: child positive parenting, $F(1, 744) = .897$, $p = .344$, caregiver positive parenting, $F(1, 749) = .160$, $p = .689$, and target and caregiver negative parenting, $F(1, 750) = 1.37$, $p = .242$. Neither the within-factors of time nor the interactions between time and change group were significant for these parenting variables. However, follow up tests showed that the change group was marginally significant for two components of caregiver positive parenting: consistent discipline, $F(1, 749) = 3.006$, $p = .083$, and positive problem solving, $F(1,749) = 3.037$, $p = .082$. These findings indicate marginally significant differences between groups such that children with the same primary caregiver at both time points received higher consistent discipline and positive problem solving than those with a change in caregiver. The within-factor of time was not significant for either variable indicating that neither variable changed significantly over time. The interaction between time and group (change vs. no change in primary caregiver) did not attain significance indicating that neither parenting consistency nor positive problem solving changed at different rates in the 2 groups.

The main effect of change in caregiver on the depressive symptoms of the caregiver was not significant, $F = 1.168$, $p = .28$, although there were significant effects of the within-

factor of time. The within-factor of time was significant for depression, $F(1, 749) = 4.376$, $p = .037$, such that mean scores on caregiver depressive symptoms were lower at Time 2 as compared to Time 1. There was no significant interaction between group and time, $F(1, 749) = .245$, $p = .621$.

The main effect of change in caregiver on receipt of public assistance was not significant, $F(1, 744) = .476$, $p = .491$. The within-factor of time was significant, $F(1, 744) = 4.970$, $p = .026$, indicating that fewer caregivers reported receiving public assistance at Time 2 as compared to Time 1. There was no significant interaction between group and time, $F(1, 744) = .000$, $p = .985$.

From Time 2 to Time 3, the effect of change in caregiver on the aggregate parenting variables was not found to be significant: child positive parenting, $F(1, 675) = .001$, $p = .981$, caregiver positive parenting, $F(1, 693) = 2.408$, $p = .121$, and target and caregiver negative parenting, $F(1, 693) = 1.29$, $p = .255$. The within-factor of time was not significant for any of the parenting variables: child positive parenting, $F(1, 675) = 1.630$, $p = .202$, caregiver parenting, $F(1, 693) = .003$, $p = .957$, and target and caregiver negative parenting, $F(1, 693) = .309$, $p = .579$. There were no significant interactions between group and time for any of the parents' ratings of parenting, although the interaction between time and group on the child report of positive parenting was marginally significant, $F(1,675) = 2.917$, $p = .088$. This means that positive parenting changed differently as a result of whether or not the child experienced a change in caregiver. For those children with a change in caregiver, their rating of positive parenting decreased from Time 2 to Time 3. The group with no change in caregiver reported an increase in positive parenting.

Of the other variables assessed from Time 2 to Time 3, only public assistance approached statistical significance. The main effect of group did not attain significance, $F(1, 647) = 2.607$, $p = .107$, although the within-factor of time was marginally significant, $F(1, 647) = 3.341$, $p = .068$. This finding indicates that the receipt of public assistance decreased across the two time points with fewer caregivers receiving public assistance at Time 3 as compared to Time 2. There was no significant interaction between group and time, $F(1, 647) = .373$, $p = .542$.

3. *What kinds of mental health and behavioral changes can be seen in adolescents who have changed primary caregivers, compared to those who have not changed caregivers?*

To examine mental health and behavioral changes that may occur in an adolescent's life context after a change in caregiver, child depression, anxiety, conduct disorder symptoms, and stressful life events scores were examined along with the child's rating of his or her school performance both before and after a change in caregiver. From Time 1 to Time 2, few mental health and behavioral changes were identified. The main effect of change in caregiver on youth conduct disorder symptoms was not significant, $F(1, 736) = 1.007$, $p = .316$. The within-factor of time was significant for youth conduct disorder symptoms, $F(1, 736) = 8.513$, $p = .004$ such that mean scores of conduct disorder symptoms were higher at Time 2 as compared to Time 1. The interaction between group and time was not significant, $F(1, 736) = .691$, $p = .406$.

For youth depressive symptoms, neither the between groups, $F(1, 737) = .045$, $p = .832$, nor the within-factor of time, $F(1, 737) = .693$, $p = .405$ was significant, although the interaction between time and group (change vs. no change in caregiver) was marginally

significant, $F = 3.124$, $p = .078$. This indicates that the children with a change in caregiver reported fewer major depressive symptoms at Time 2 as compared the Time 1 relative to those who did not change caregivers. None of the other variables was found to be statistically significant. None of the analyses involving mental health or behavioral changes obtained significance from Time 2 to Time 3. This appears to indicate that a change of caregiver within the African American family context does not necessarily mean that children will experience severe mental and behavioral problems.

4. *What characteristics of the new caregiving situation predict good versus poor outcomes of the child?*

To answer this question, a series of regression analyses was conducted. A separate regression was conducted predicting each of the following youth outcome measures: depressive symptoms, conduct disorder symptoms, and school performance. In these analyses, children who did not change caregiver during the study were excluded. In each equation, the previous score on the outcome measure (before caregiver change) was entered, along with demographic characteristics of the primary caregiver (age, gender, education level), and the Time 1 and Time 2 parenting practices, parental depression and child's stressful life events. By including Time 1 and Time 2 values in the equation, we were able to examine the impact of change in predictors on change in the outcome variable. When controlling for the Time 1 value, the Time 2 value represents change on that construct. None of the regression equations attained overall significance, although the model predicting child depressive symptoms was marginally significant at Time 2, $F(14, 21) = 2.784$, $p = .089$. The model explained 54.3% of the variance (adjusted $R^2 = .543$). Results of each analysis are shown, however, to examine the contributions of individual predictor variables to outcomes.

Turning first to the predictors of child depressive symptoms at Time 2, caregiver positive parenting at Time 2 (t = -2.41, p = .047) attained significance (see Table 8). This signifies that children whose quality of parenting improved became less depressed and those whose quality of parenting deteriorated after the change in caregiver became more depressed. Child stressful life events at Time 1 (t = 2.75, p = .029) was also a significant predictor. Youth who experienced a higher level of stressful life events at Time 1 increased from Time 1 to Time 2 in depressive symptoms. Caregiver education (t = 1.93, p = .094) was a marginally significant predictor, indicating a trend towards increasing depression overtime among youth who moved away from the home of a more highly educated caregiver.

Turning next to predictors of school performance at Time 2, the overall model failed to attain significance, $F(14, 21) = 1.502$, p = .302, as shown in Table 9. School performance at Time 1 was a marginally significant predictor of school performance at Time 2 (t = 1.91, p = .097). No other variable approached or attained statistical significance.

Table 10 shows the contribution of individual predictor variables to youth conduct disorder at Time 2. Caregiver age emerged as a significant predictor of youth conduct disorder (t = -2.69, p = .036). Greater age of the Time 1 caregiver was associated with fewer conduct disorder symptoms at Time 2. Caregiver gender emerged as a marginally significant predictor of youth conduct disorder at Time 2 (t = 1.99, p = .093). Youth with a female caregiver at Time 1 showed a tendency to display more conduct disorder symptoms at Time 2.

I will next turn to predictors of youth depressive symptoms, school performance, and conduct disorder symptoms at Time 3 among youth who changed caregivers from Time 1 to Time 3. The overall model did not attain significance for youth depressive symptoms,

Table 8

Regression Analysis Predicting Depressive Symptoms at Time 2 Among Children Who Changed Caregivers From Time 1 to Time 2

	B	*SE B*	ß
Child Depression 1	-.56	.51	-.67
Caregiver Age	.33	.18	.82
Caregiver Education	2.35	1.22	.67†
Caregiver Gender	.09	2.35	.01
Parental Depression 1	.32	.65	.14
Parental Depression 2	.55	.87	.15
Caregiver Positive Parenting 1	.97	2.69	.11
Caregiver Positive Parenting 2	-8.28	3.44	-1.24*
Child Positive Parenting 1	.50	2.55	.08
Child Positive Parenting 2	.86	1.60	.18
Child and Caregiver Neg. Parenting 1	-.62	2.18	-.10
Child and Caregiver Neg. Parenting 2	3.10	2.28	.48
Child Stressful Life Events 1	.72	.26	.98*
Child Stressful Life Events 2	-.56	.51	-.67

Note. $R^2 = .54$ ($p = .089$).

†$p < .10$. *$p < .05$.

Table 9

Regression Analysis Predicting Children's School Performance at Time 2 Among Children Who Changed Caregiver From Time 1 to Time 2

	B	*SE B*	ß
Child School Performance 1	.71	.37	.75†
Caregiver Age	.04	.03	.47
Caregiver Education	-.09	.23	-.12
Caregiver Gender	.36	.66	.15
Parental Depression 1	-.03	.15	-.05
Parental Depression 2	-.07	.23	-.09
Caregiver Positive Parenting 1	-.45	.80	-.25
Caregiver Positive Parenting 2	.57	.64	.39
Child Positive Parenting 1	.20	.52	.17
Child Positive Parenting 2	-.17	.28	-.16
Child and Caregiver Neg. Parenting 1	.05	.35	.04
Child and Caregiver Neg. Parenting 2	-.26	.41	-.19
Child Stressful Life Events 1	-.04	.08	-.22
Child Stressful Life Events 2	.01	.06	.03

Note. $R^2 = .25$ ($p = .302$).

†$p < .10$.

Table 10

Regression Analysis Predicting Children's Conduct Disorder at Time 2 Among Children Who Changed Caregiver From Time 1 to Time 2

	B	*SE B*	ß
Child Conduct Disorder 1	.40	.29	.37
Caregiver Age	-.205	.08	-.79*
Caregiver Education	.27	.59	.13
Caregiver Gender	3.53	1.77	.52†
Parental Depression 1	-.13	.41	-.09
Parental Depression 2	.56	.66	.25
Caregiver Positive Parenting 1	3.10	2.04	.57
Caregiver Positive Parenting 2	-1.96	1.41	-.46
Child Positive Parenting 1	-1.33	1.69	-.35
Child Positive Parenting 2	.40	1.11	.13
Child and Caregiver Neg. Parenting 1	-1.21	1.72	-.31
Child and Caregiver Neg. Parenting 2	1.17	1.71	.30
Child Stressful Life Events 1	.09	.18	.20
Child Stressful Life Events 2	.10	.16	.17

Note. $R^2 = .31$ ($p = .278$).

†$p < .10$. *$p < .05$.

$F(14, 24) = 1.48$, $p = .269$. Table 11 shows the contributions of individual variables to outcomes. Child stressful life events at Time 2 and Time 3 emerged as significant predictors of child depressive symptoms at Time 3, ($t = -2.28$, $p = .046$) and ($t = 3.4$, $p = .006$) respectively. The unexpected negative relationship between stressful events at Time 2 and depression at Time 3 appears to be an artifact of multicollinearity between the Time 2 and Time 3 stress variables ($r = .38$, $p < .01$). Examination of the correlation matrix in the appendix reveals that the simple correlation was positive between Time 2 stressful life events and Time 3 depression. The positive beta weight for Time 3 stressful events indicates that where stressful life events increase from Time 2 to Time 3, children's depression scores increase as well. When the new household presents more stressors than the previous household, youth become more depressed following the move.

The model predicting school performance at Time 3 failed to attain significance, $F(14, 24) = .97$, $p = .53$. None of the individual predictor variables attained significance (see Table 12).

The model predicting youth conduct disorder symptoms at Time 3 was statistically significant, $F(14, 24) = 2.84$, $p = .05$, as can bee seen in Table 13. The model explained 52.1% of the variance (adjusted $R^2 = .518$). Youth conduct disorder at Time 2 was found to be a marginally significant predictor of youth conduct disorder at Time 3 ($t = 1.91$, $p = .085$). Youth with more symptoms at Time 2 had more symptoms at Time 3. Caregiver education and target stressful life events at Time 3 emerged as significant predictors, ($t = -2.20$, $p = .053$) and ($t = 2.71$, $p = .022$), respectively. Youth whose Time 2 caregiver had more education displayed fewer conduct disorder symptoms at Time 3. Youth who experienced an

Table 11

Regression Analysis Predicting Depressive Symptoms at Time 3 Among Children Who Changed Caregiver From Time 2 to Time 3

	B	*SE B*	ß
Child Depression 2	.61	.50	.43
Caregiver Age	-.02	.11	-.05
Caregiver Education	-1.61	1.11	-.40
Caregiver Gender	-.78	5.89	-.06
Parental Depression 2	-.08	1.11	-.03
Parental Depression 3	.93	1.15	.31
Caregiver Positive Parenting 2	2.12	2.07	.27
Caregiver Positive Parenting 3	1.45	2.02	.25
Child Positive Parenting 2	-1.25	1.73	-.18
Child Positive Parenting 3	.53	1.30	.10
Child and Caregiver Neg. Parenting 2	1.25	2.12	.20
Child and Caregiver Neg. Parenting 3	-3.10	3.91	-.40
Child Stressful Life Events 2	-.92	.40	-.74*
Child Stressful Life Events 3	.10	.29	1.09**

Note. $R^2 = .23$ ($p = .256$).

*$p < .05$. **$p < .01$

Table 12

Regression Analysis Predicting Children's School Performance at Time 3 Among Children Who Changed Caregivers From Time 2 to Time 3

	B	*SE B*	ß
Child School Performance 2	.24	.20	.34
Caregiver Age	.01	.02	.13
Caregiver Education	.19	.16	.39
Caregiver Gender	.27	.70	.17
Parental Depression 2	.05	.17	.13
Parental Depression 3	-.23	.16	-.61
Caregiver Positive Parenting 2	-.00	.29	-.00
Caregiver Positive Parenting 3	-.45	.29	-.62
Child Positive Parenting 2	-.22	.26	-.25
Child Positive Parenting 3	-.13	.19	-.19
Child and Caregiver Neg. Parenting 2	.07	.32	.08
Child and Caregiver Neg. Parenting 3	.38	.41	.39
Child Stressful Life Events 2	.04	.06	.25
Child Stressful Life Events 3	-.06	.04	-.52

Note. R^2 = -.02 (p = .54).

Table 13

Regression Analysis Summary for Variables Predicting Children's Conduct Disorder Symptoms at Time 3

	B	*SE B*	ß
Child Conduct Disorder 2	.68	.36	.58†
Caregiver Age	.01	.07	.05
Caregiver Education	-1.36	.61	-.48*
Caregiver Gender	-.36	2.72	-.04
Parental Depression 2	-.52	.66	-.24
Parental Depression 3	.83	.66	.38
Caregiver Positive Parenting 2	.28	1.10	.05
Caregiver Positive Parenting 3	.99	1.12	.24
Child Positive Parenting 2	-.1.88	1.11	-.38
Child Positive Parenting 3	.60	.73	.16
Child and Caregiver Neg. Parenting 2	-.81	1.18	-.17
Child and Caregiver Neg. Parenting 3	-1.75	1.61	-.32
Child Stressful Life Events 2	-.23	.23	-.26
Child Stressful Life Events 3	.44	.16	.68*

Note. $R^2 = .52$ ($p = .05$).

†$p < .10$ *$p < .05$.

increase in stressful life events also experienced an increase in conduct symptoms from Time 2 to Time 3.

5. *At each time point, was there a significant difference in the number of conduct disorder symptoms, depressive symptoms, and school performance for targets who were currently living with a biological parent, other relative, or a non-relative?*

To answer this question a series of one-way ANOVAs was conducted in which the independent variable was the relationship of the target child to his or her current primary caregiver (biological parent, other relative, or a non-relative). A separate set of analyses was conducted for Time 1, Time 2, and Time 3 variables. The dependent measures were number of conduct disorder symptoms, depressive symptoms, and school performance. At Time 1, number of youth conduct disorder symptoms was significantly lower for children who were living with their biological parent, $F(2, 876) = 3.53$, $p = .03$. Neither youth depressive symptoms nor school performance differed significantly by rearing group, $F(2, 876) = 3.71$, $p = .69$, and $F(2, 886) = 3.87$, $p = .68$, respectively.

At Times 2 and 3, the caregiver's relationship to the child did not significantly impact the child's conduct disorder symptoms, depressive symptoms or school performance.

6. Was there a significant difference in the number of conduct disorder symptoms, depressive symptoms, and school performance for children who were consistently raised by biological parent, relatives, and non-relatives?

To answer this question a series of ANOVAs was conducted in which the independent variable was the consistent relationship of the target child to his or her primary caregiver (biological parent, other relative, or a non-relative) and the dependent measures were the Time 3 ratings of number of conduct disorder symptoms, depressive symptoms, and

school performance. Only children who remained with the same caregiver across all three time points were included in the analysis. The caregivers' relationship to the child did not significantly impact the child's conduct disorder symptoms, depressive symptoms, or school performance.

DISCUSSION

This study was designed to assess both the predictors and consequences of a change in caregiver among African American children. Children's level of depression and conduct disorder symptoms and school performance were assessed in order to compare the adjustment of children who reside with a biological parent compared to that of children who live with various other family members and non-relatives. The sample consisted of African American children being raised by various members of their families including biological parents, relatives, and non-relatives.

Understanding the circumstances in which children experience a change in caregiver is important. There are a number of variables that may affect biological parents' ability to continuously care for their children. Researchers have hypothesized that lack of resources, drug use, and psychological symptoms may influence caregiver's ability to provide care (Brody & Flor, 1998; Kotchick, Dorsey, & Heller, 2005; Pilowsky et al., 2001). In many lower socioeconomic status families, problems with inadequate housing as well as access to healthcare services are common. Parental drug use has been identified as one of the most influential factors that affect caregiver status (Pilowsky et al., 2001). The drug seeking behaviors and lifestyle choices of drug addicted caregivers may be place the child in grave danger. Research shows that children of substance abusing caregivers are at increased risk for health, behavioral, psychological, and academic problems (Wilens, Biederman, Kiely, Bredin, & Spencer, 1995).

Parental psychological distress can negatively impact the way in which a parent interacts with his or her child. Research has indicated that psychological symptoms affect the development and maintenance of a positive parent-child relationship (Kotchick, Dorsey, &

Heller, 2005). Parental psychological distress has been associated with less maternal monitoring of children's activities, and more lax or inconsistent discipline practices (Kotchick, Dorsey, & Heller, 2005). Because of the detrimental effects of this sort of parenting on child outcomes, another home environment may be a better option for a child.

Caregivers who are young teenagers are likely to discontinue offering care to children (Gebel, 1996). With young teenagers, it is often the mother's parent who assumes the role of caregiver. This is primarily an issue because young teenagers cannot handle the cost and responsibility of children. According to the 2000 census, about 500,000 African American grandparents in the United States identified themselves as the primary caregiver of their grandchildren (Minkler & Fuller-Thomson, 2005). This equates to about 9% of African American children under age 18 being raised in grandparent-headed households (Minkler & Fuller-Thomson). This number is relatively close to the proportion in the present study, where it was found that about 5% of caregivers identified themselves as grandparents.

It seems important to note that in our sample, changes in caregiver, from biological parent to grandparent, appear to be happening fairly early in the child's life. By our first wave of data collection, the children in the sample were about 10 years old and about 50 children had already been placed under the care of a grandparent. The idea that such moves occur early in the child's life is also supported by the fact that no one in our sample actually reported moving from the home of a biological parent to the home of a relative, not even a grandparent.

In my study, caregiver age predicted a change in caregiver. Unexpectedly, I found that as caregivers' age increased, the more likely it was that the child experienced a change in caregiver. One possible reason that age is a significant predictor of a change in caregiver may

be related to older individuals' decreased ability to monitor and properly care for young children. For example, grandparents who have already brought up one generation of children may be overwhelmed by the responsibility of raising another generation of children because they are experiencing increased physical health problems (Ruiz, Zhu, & Crowther, 2003). Raising children also brings with it many responsibilities of a financial nature. If children are moving to the homes of grandparents with financial resources, then this is not an issue. But the grandparents who are raising children tend to be female, younger, and less educated than non-caregiving grandparents and are also more likely to be living in poverty and receiving public assistance (Minkler & Fuller-Thomson, 2005).

Caregiver gender was also found to be significant predictor of a change in caregiver. Though there were few male caregivers in this study, the results indicated that children with a male caregiver were more likely to experience a change in caregiver. I speculate that this may be the case because women are socialized to be more nurturing and may be more willing to maintain the role of caregiver to children.

Because we did not ask about the circumstances that led to changes in caregivers, it is unclear if caregivers are seeking out new living situations for their children, or if the changes in caregivers are prompted by some outside party (i.e., the Child Welfare Services) or someone in the child's life who feels that the child could benefit from a change in caregiver. This distinction seems important because it is not clear from the data whether older, uneducated, male caregivers are offering their children to a new caregiver or whether they are being told that a new caregiver situation is necessary. Future research should focus on who is prompting the moves as well as the specific predictors of a change in caregiver in order to better understand this phenomenon.

Initial level of depression did not predict whether or not children changed caregivers. However, from Time 1 to Time 2 among children who changed caregivers, it appears that caregivers at Time 2 reported less depression than those at Time 1. This seems to mean that children were moved to homes of caregivers who were less depressed than their previous caregiver and therefore, in a better mental state to care for children. Research shows that depressed parents are less involved in the lives of their children and also that the parenting to children by depressed parents is of poor quality (Hammen, 1999).

Youth who changed caregivers appear to have perceived some deterioration in the quality of parenting they received. Children who changed caregivers from Time 2 to Time 3 showed a decrease over time on the self-report measure of positive parenting. Level of positive parenting increased over time for the children who did not change caregivers. This seems to mean that after children experience a change in caregiver, they have to adjust to the expectations of the new caregiver. Considering that the change in parenting was only significant from the perspective of the child, it seems possible that the children with a change in caregiver rated their new caregiver situation as less adequate. Imagine the perspective of a child who did not want to leave his or her previous home environment. This child may be struggling to adjust to the new caregiving situation and thus rate it as less positively. After a change in caregiver, children also tended to report less consistent discipline as well as less positive problem solving. Again, this may be a manifestation of the child's resistance to change.

When predicting good versus poor outcomes in children after a change in caregiver it seems logical that caregiver parenting characteristics, such as inductive reasoning, problem solving and monitoring, are good predictors of child adjustment. I found that the more a

caregiver displayed these positive parenting characteristics, the less likely it was that the child would experience depression after a change in caregiver. Conversely, when quality of parenting deteriorated, children reported greater depression.

Children who experienced a change in caregiver reported slightly fewer major depressive symptoms at Time 2 except when they moved away from the home of a more educated caregiver. Children tended to report a slight increase in depression when moving from the home of more educated caregiver. The connection between parental education and child depression is an interesting one that should be addressed in future research. It may be that better parenting practices are employed by more educated caregivers.

Research has supported the notion that stress and negative adjustment are significantly associated (Wingate & Joiner, 2004). Consistent with this finding, I found that stressful life events in the child's life at the previous time point predicted an increase in child depressive symptoms, regardless of whether the child changed caregivers or not. Also, when the new household presented more stressors than the previous household, children reported becoming more depressed following the move. A significant relationship between stressful life events and major depressive symptoms emerged among children with and without a change in caregiver. Past stressful life events were associated with increased depression across all 3 waves of data collection.

A significant relationship between stressful life events and conduct disorder symptoms also emerged in the data. Youth who experienced an increase in stressful life events over time also experienced an increase in conduct disorder symptoms. Intuitively, this finding makes sense. When children experience stressful life events, especially if their emotional reactions to these experiences are not addressed, it may lead to feelings of

depression, and helplessness, which may later be manifested as conduct disorder symptoms. Based on research by Groves (2002), it seems reasonable to hypothesize that unresolved reactions to negative life stressors play a significant role in the conduct disorder symptoms presented by the children in this study. If this is the case, counseling might be helpful.

Across all children in the sample, there was an increase in conduct disorder symptoms as the study progressed. This finding was not dependent on the child's relationship to his or her caregiver, although conduct disorder symptoms were lower for children living with a biological parent. Caregiver age and education level were significant predictors of conduct disorder symptoms. Specifically, greater caregiver age at Time 1 was associated with fewer conduct disorder symptoms at Time 2. This means that children with older caregivers displayed and reported fewer conduct disorder symptoms. One possible reason children with older caregivers reported fewer conduct disorder symptoms may be related to the parenting strategies of older caregivers. In traditional African American families, harsh and often physical, discipline is thought to an acceptable form of child rearing. It may be that older caregivers implement such parenting tactics more than younger caregivers. In African American culture, such stern parenting is widely viewed as an effective way to "keep children in line" (Deater-Deckard, Bates, Dodge, & Pettit, 1996). It also may be possible that children have greater respect for their older caregivers and feel less need to act out.

Although much can be learned about African American families from this study, it is not without limitations. Because only a small number of the children experienced a change in caregiver, some of the analyses lacked statistical power. Another limitation of the present study is related to the use of secondary data. Because the data were collected before the current study was designed, variables that would allow full exploration of relationship

dynamics were not included in the data set. For example, attachment style and its role in the children's changes in caregiver could not be explored in the current study. Future researchers should also examine the precipitating events that lead up to changes in caregivers and the factors that play into multiple move.

The study also had notable strengths. Because this was a longitudinal study, data were collected over the course of multiple time periods, which allowed me to analyze variables at three different stages of adolescents' development. Because data on changes in life context, behavioral patterns, and emotional experiences were reported by both the child and the caregiver, comparisons could be made that assessed the consistency and discrepancies between child and caregiver perspectives.

There is a growing tendency to place children in kinship care in the event of family breakdown. This has become the preferred option for of out-of-home placement, a development that emerged as a child welfare issue in the late 1980s (Holton, Ronning, Handegard, & Sourander, 2005), but is this necessarily the best option for the child? It seems that these placements are beneficial to children as long as the new caregiving situation is at least comparable, if not better than their previous situation.

Children who experience a change in caregiver may benefit from counseling to deal with the effects of moving from one home to another. It is expected that children with a change in caregiver will adjust and adapt to new rules of the current living situation, new norms, and a different set of expectations from the new caregiver. Feelings of helplessness may result after a change in caregiver primarily because the initiation of the move is often out of their control. Children may also experience feelings of guilt or blame following a change in caregiver, similar to the reactions of some children of divorced parents.

From this study, I found relatively few differences in the adjustment of children who changed in comparison to those who did not change caregivers. It seems that the transition from one caregiver to another is minimally distressing for the children in the study. This conclusion is consistent with my original hypothesis that family networks provide a familiar environment for children transitioning from one caregiver to another, thus minimizing the effects of the transition. Many of the transitions involved non-relatives; therefore, it is the resiliency of the children in this study that seems to explain their ability to adjust. For this reason, the resiliency of African American children who experience changes in caregivers should be addressed by future research.

A major contribution of the present study is the light it sheds on the experiences of African American children being raised by caregivers other than their biological parent. Whether children are being raised by biological parents, relatives, or non-relatives, the important piece to remember is that children need to be raised in environments that encourage their healthy behavioral and psychological development.

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APPENDIX

Intercorrrelations for Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. PC Age	--												
2. PC Education	.09**	--											
3. PC Gender	-.08*	-.09**	--										
4. PC Parenting Variables 1	-.05	-.01	-.05	--									
5. PC Parenting Variables 2	.03	-.11	-.03	.57**	--								
6. PC Parenting Variables 3	-.02	-.02	-.08*	.44**	.51**	--							
7. Target and PC Negative Parenting 1	-.08*	-.06	.05	.17**	.18**	.19**	--						
8. Target and PC Negative Parenting 2	-.11**	-.11**	.04	.16**	.22**	.21**	.39**	--					
9. Target and PC Negative Parenting 3	-.12**	-.03	.10**	.13**	.22**	.28**	.33**	.45**	--				
10. Target Positive Parenting 1	.03	.04	.01	-.22**	-.13**	-.13**	-.22**	-.12**	-.10**	--			
11. Target Positive Parenting 2	.02	.01	.05	-.23**	-.24**	-.21**	-.21**	-.28**	-.18**	.39**	--		
12. Target Positive Parenting 3	-.01	-.04	-.02	-.23**	-.21**	-.32**	-.14**	-.22**	-.33**	.31**	.46**	--	
13. PC General Depression 1	-.11	-.14**	.07*	.16**	.06	.09*	.09**	.09*	.12**	-.08*	-.03	-.08*	--
14. PC General Depression 2	-.04	-.11**	.09*	.12**	.15	.09*	.07*	.14**	.14**	-.04	-.08*	-.03	.46**
15. PC General Depression 3	-.03	.16**	.04	.07	.09	.13**	.07	.11**	.13**	-.02	-.05	-.04	.34**
16. School Performance 1	.03	.12**	-.01	-.06	-.09*	-.04	-.09	-.12**	-.11**	.16**	.11	.07	-.02
17. School Performance 2	.06	.16**	.04	-.13	-.13**	-.13**	-.03	-.09**	-.07	.07*	.12	.07	-.07
18. School Performance 3	.02	.14**	.01	-.08*	-.05	-.07	.02	-.05	.03	.06	.03	.07*	-.11**
19. Target Stressful Life Events 1	-.01	-.13**	-.04	.13**	.12**	.11**	.34**	.25**	.17**	-.17**	-.18**	-.12**	.14**
20. Target Stressful Life Events 2	-.03	-.11**	-.03	.08*	.11**	.11*	.19**	.36**	.21**	-.09*	-.16**	-.08*	.09*
21. Target Stressful Life Events 3	-.02	-.02	.02	.07*	.13**	.16**	.07*	.21**	.33**	-.02	-.14**	-.17**	.09*
22. Target Conduct Disorder Symptoms 1	.03	-.06	-.05	.12**	.13**	.20**	.26**	.19**	.15**	-.25**	-.18**	-.19**	.04
23. Target Conduct Disorder Symptoms 2	.03	-.05	-.08*	.16**	.21**	.16**	.24**	.34**	.24**	-.15**	-.27**	-.18**	.05
24. Target Conduct Disorder Symptoms 3	.01	.02	.03	.16**	.16**	.21**	.13**	.24**	.28**	-.14**	-.21**	-.28**	.06
25. Target Major Depressive Symptoms 1	.04	.01	-.01	.09**	.03	.08*	.18**	.11**	.05	-.16**	-.07*	-.09*	.08*
26. Target Major Depressive Symptoms 2	.01	-.03	-.13**	.03	.05	.04	.12**	.28**	.18**	-.09*	-.12**	-.01	.12**
27. Target Major Depressive Symptoms 3	.07	-.04	-.01	.02	.05	.07	-.01	.10**	.16**	-.02	-.07	-.11**	.07
28. Different Caregiver	.24**	.11	-.15	.01	.02	.05	.00	-.04	-.06	.06	.05	-.01	.01
29. Stable Biological Parent	-.61**	.03	.10*	-.02	-.03	-.07	.07	.06	.08*	.05	.01	.04	.03

*$p < .05$. **$p < .01$

	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
1.																
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15.	.50**	--														
16.	.01	.04	--													
17.	-.03	-.08*	.27**	--												
18.	-.04	-.07	.14**	.27**	--											
19.	.05	.06	-.11**	-.10**	-.08*	--										
20.	.08*	.08*	-.11**	-.11**	-.06	.48**	--									
21.	.07	.14**	-.03	-.03	-.09*	.25**	.38**	--								
22.	.03	.02	-.11**	-.10**	-.05	.39**	.27**	.12**	--							
23.	.10**	.10**	-.15**	-.11**	-.07	.33**	.44**	.31**	.43**	--						
24.	.06	.04	-.08*	-.09*	-.09*	.19**	.33**	.47**	.31**	.52**	--					
25.	.10	-.01	-.04	-.08*	-.08*	.37**	.19**	.17**	.38**	.19**	.17**	--				
26.	.11**	.05	-.07	-.13**	-.06	.26**	.41**	.28**	.15**	.37**	.20**	.31**	--			
27.	.06	.04	-.01	-.05	-.04	.06	.21**	.43**	.03	.11**	.34**	.18**	.32**	--		
28.	-.02	-.03	.04	.01	.03	.03	-.02	-.02	.03	.03	.03	.01	-.03	-.00	--	
29.	.03	.06	-.01	.03	.01	-.04	-.02	-.02	-.11**	-.11**	-.05	-.05	-.08*	-.07	-.62**	--